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4 000	Initial Comments A re-licensing survey was conducted by the Office of Health Care Assurance (OHCA) on 01/29/20. The facility was found not to be in substantial compliance with Title 11 Chapter 94.1 Nursing facilities. Survey Dates: January 29, 2020 to February 3, 2020. Survey Census: 161 Sample Size: 32 One complaint Aspen Complaint Tracking System (ACTS) intake number 7951 was investigated and not substantiated. One Facility reported incident (FRI), ACTS intake number 7856 was investigated and not substantiated.	4 000		
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on interview, record and policy review, the	4 118	On 2/5/2020 the Advance Directive Policy	3/17/20

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4 118	Continued From page 1 facility erroneously documented that Resident (R) 111 had a copy of an advance health care directive (AHCD) in his medical chart. No current copy of R111's AHCD was found in the resident's medical record as indicated on his admission paperwork dated on 01/06/2020. Findings include: 1. In the "Resident Agreement" for R111, dated 01/06/20, under "Admission Acknowledgements", the box was checked for "I have provided an Advanced Healthcare Directive." No AHCD was found in the electronic and paper chart for R111. On R111's care plan, it was stated that R111 declined having an AHCD. In an interview with the social worker (SW) 1, on 01/31/20 at 02:35 PM, she stated that R111 had been declining to complete his AHCD. The facility's Policy & Procedure on Advance Directives state, "Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives."	4 118	and Procedure was updated. The admissions staff and administrator reviewed the new resident admission process on 3/17/2020. The advance directive education material was found to be a component part of the current admission process. New residents are given state developed education to support the importance of advance directives. This material is discussed and an acknowledgement is completed by the resident/family. The revised policy statement regarding advance directives will be provided to all new admissions. The Admission Nurse Coordinator created a new admission checklist for the ward clerk staff which includes identifying whether or not an Advance Directive was previously completed. If so, the ward clerk staff are to electronically scan the Advance Directive into the electronic medical record. The Medical Records Director will perform a chart audit on each newly admitted resident on a daily basis. A monthly audit is performed by the social services department to identify residents whose advance directive information is complete. The social services department will also help the resident/family in the completion of the advance directive. The Director of Social Services will report at the monthly QAPI meeting the status of any outstanding advance directive concerns.	

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4 120	Continued From page 2	4 120		
4 120	1-94.1-27(9) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on observation and interview, the facility failed to provide the information on how to file a grievance and place the forms in an accessible location for the residents residing in the facility. The facility failed to provide the contact information for the State long term care ombudsmen. Findings include: Surveyor and DON did a walk through on 01/31/20 at 0730 AM to look for the written forms for the residents to file a grievance. The form on unit (U)3 was located at the nurse's station. DON stated that the form is given out when a resident request it from the staff. So, it is the responsibility of the staff to follow through and give the form to the resident. The family and residents upon admission are educated about the process for filing a grievance. Surveyor shared that the resident's at the resident council meeting reported they did not know about the grievance form or the process. The residents stated that in the past they have taken their concerns to the	4 120	On 2/4/2020 the Grievance Policy and procedure was reviewed and updated. The policy statement was changed to include: -Reassignment of the grievance officer. The Director of Social Services has been appointed the facility Grievance Officer. The resolution of all grievances is a function of the IDT, and closure of the grievance will now be the responsibility of the S.S. Director. -Increased the accessibility of the grievance forms =Each nursing unit and the front desk has a folder which holds the following: 1) How to file a grievance notice 2) Grievance Forms 3) Grievance Investigation Forms -New 2020 Grievance Binder made to include: 1) Grievance tracking log 2) Tabs for each month 3)Grievance Form 4)Grievance Investigation Form	2/4/20

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4 120	Continued From page 3 supervisor or manager and and that it goes nowhere. The DON stated its her goal to educate the residents about the location and use of the grievance form. Surveyor and DON observed the bulletin board located on U4, and VC1. The residents from the other units would have a very difficult time accessing the information posted there due to the pathway to the elevator. The DON agreed that it is not visible for the residents and stated that she would probably be moving the board to a better location. DON agreed that the residents are not aware of the process and need to be educated.	4 120	5)Grievance Follow Up Form -The Staff Development Coordinator will provide education for new updated grievance policy and procedure -Structure of grievance forms updated =Grievance Form =Grievance Investigation Form =Grievance Follow Up Form Current & outstanding grievances are reviewed and discussed in daily standup meetings as a part of our QAPI process. IDT members who would assist in resolving the grievances are identified. Investigation and resource application is completed by the grievance officer. Resolved grievances are presented in the standup meetings by the grievance officer. All grievances within a month are discussed again at the monthly QAPI meetings. The admission process now includes a review of outside resources available which residents may use to acquire support as indicated.	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration;	4 136		4/3/20

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4 136	Continued From page 4 (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure Three resident's (R)2 and R60, and R111 received care that was within professional nursing standards of practice. R2 did not receive the correct texture of food based on nutritional assessment and provided 1:1 supervision with meals according to the comprehensive care plan. As a result of this deficiency, R2 was at risk for choking and inadequate nutritional intake. R60 developed a chronic non-healing Stage four facility acquired pressure ulcer which resulted in infection. Cross reference with F657, F686, F725. Findings include: 1) R2 was admitted to the facility on 02/19/15. A review of R2's Minimum Data Set (MDS) documenting a significant change in condition (readmission to the facility following a hospitalization) with an Assessment Reference Date of 11/2/19 documents, R2 Brief Mental Status (BIMS) score is 00 indicating severe cognitive impairment. R2 requires extensive assistance for eating, with one staff assistance. R2 weighed 94 pounds (lbs), had loss 5% or more in the last month or loss 10% or more in the last 6 months, and was not a a physician prescribed weight loss plan.	4 136	As of 3/15/2020 R60 was discharged from the facility. On 2/7/2020 education was provided to Dietary staff including topics of appropriate dietary restriction and textures. Dietary Manager reviewed the menu extensions and provided education to dietary staff on reading/interpretation of the correct dietary order and ensuring the appropriate texture is included in each resident's meal as the food is prepared on the tray line. Included in the nursing staff new hire orientation program which began on 3/31/2020 the dietary manager provided information on dietary services and diet consistency. The dietary manager will continue to provide education to the nursing staff though informal huddles surrounding dietary management including dietary order review, diet consistency and texture. To address residents' skin and weight concerns the facility has organized monthly skin and weight meetings. These meetings will include the dietary manager, unit managers, dieticians, ADON, & DON. The meeting will address the following: -New admissions	

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4 136	Continued From page 5 A review of the electronic medical record (EMR), on 09/09/2019, the R2 weighed 107 lbs and on 01/03/2020, the resident weighed 95.2 pounds which is a -11.03 % Loss. On 02/03/20 at 12:01 PM, a review of R2's care plan documented has an ADL self care performance deficit due to general weakness, limited mobility, dementia, and a history of stroke. been needing more assistance in ADL range with 1-2 person- Eating- The resident is able to feed self after set up- 02/26/15 not updated. Also, R2 is at risk for fluid-nutritional deficit related to: unreliable intake, history of chewing/swallowing deficit. The resident has had a significant weight loss greater than 10% (10/30/19) in 180 days. Interventions listed included: Encourage cue assist or feed as needed to complete at least 50% of meals, at least 360 cc fluids with meals, and 120 cc fluid between meals. On 01/29/20 12:53 PM, lunch was distributed to R2. R2 needed assistance setting up removing the covers from food, and no assistance being provided. On 01/29/20 01:59 PM, observed R2 seated in her wheelchair, with lunch set up on a table in front of the resident. Lunch included a bowl of chopped up noodles with 3 large pieces of broccoli. R2 was having difficulty feeding herself and would drop 90% of food from the fork onto the table in front of her. Observed the resident attempted to break the broccoli with her finger but was unsuccessful. As a result of not being able to break apart the broccoli, R2 did not eat any of the broccoli. Furthermore, the over half of the soup which was also served for lunch had spilled onto the tray, when R2 attempted to feed herself. Certified nurse aide (CNA) staff was present in the room, assisting another resident with lunch. R2 was not given any assistance.	4 136	-Residents with wounds -Weight loss -Weight gain Pressure Ulcer management education was provided to the nursing care staff during the meetings on 3/18 - 3/19/2020 focusing on the importance of resident position and turning. The facility has adapted the use of a turning clock to be used to identify a timeframe for which the staff will be turning the residents. The turning clock tool was inserted into daily nursing practice on 4/1/2020. Follow up education will be provided through informal staff huddles on 4/2 and 4/3/2020. The SDC will provide education for wound assessment and classification through the upcoming skills fair (4/13 - 4/17/2020) and ongoing staff in-services. The Aloha Wound Care team does a weekly in house visit to assess, debride and give treatment recommendations. Through the past several months the nursing leadership has been working with the EMR resources to facilitate the implementation of a Skin & Wound software. This program will help tracking and review of current and new wounds. It will aid nursing staff with the assessment and appropriate documentation of these wounds. The wound care coordinator is a component part of the Aloha Wound Care team and is a staff member of the facility. Wound care coordinator will be responsible for auditing the condition of	

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4 136	Continued From page 6 On 02/03/20 at 11:08 AM, reviewed R2's EMR with Nurse Manager (NM)4. On 01/29/20 at lunch, staff documented R2 ate 1-25% of lunch. NM4 confirmed that staff does not help R2 with lunch. An interview with the Registered Dietician (RD) confirmed the broccoli R2 received should have been chopped into smaller pieces. 2) R60 is an 80 year old female with a Diagnosis of stage four pressure ulcer of the sacrum. During several observation's of R60 on 01/30/20 at the following times: 11:45 AM; 12:30 PM; 01:15 PM; 02:00 PM; noted the resident was laying in bed in semi fowlers position on her back without being repositioned. During an observation on 01/31/20 at 09:10 AM noted R60 slightly elevated in bed being assisted with her breakfast meal by the RNA. During additional observations at 10:30 AM; 11:00 AM; and 12:15 PM noted R60 sitting in same position with eyes closed. During several observations of R60 on 02/03/20 at the following times: 08:10 AM; 09;17 AM; 10:00 AM; and 11:30 AM noted R60 lying in bed on her back in the same position. During an interview with Licensed Nurse (LN)52 on 01/30/20 at 02:06 PM confirmed that R60 has a stage 4 pressure ulcer to the sacrum acquired in the facility on 03/3/19. LN52 stated that R60 is not receiving the Wound care clinic services because her insurance coverage is with a different provider that won't cover the service. They tried to get it approved but it was denied. There is a Nurse Practitioner who comes 1-2 times per week to look at the wound and write the	4 136	the resident's wounds and providing care direction and feedback to the nursing staff. At the monthly QAPI meeting the wound care coordinator will give a report of the progress of the wounds managed by the Aloha Wound Care Team.	

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4 136	Continued From page 7 treatment orders. The dressing is changed in the early morning and evening shift or when she makes a bowel movement (BM). Electronic Medical Record (EMR) reviewed. Following Skin observation tool's reviewed: 03/13/19; open skin to sacral area stage 2 with treatment (tx) of bacitracin covered with foam dressing after cleansing with normal saline (NS). 04/23/19; open skin to sacral area with tx of bacitracin covered with foam dressing daily & PRN. 05/29/19; stage 4 sacral injury appears moist 80 percent (%) slough yellowish-brownish adherent tissue, surrounding skin slightly reddened and partially macerated wound edges. 06/04/19; treatment plan changed to the following: cleansed with dakins solution applied Santyl to slough area and medihoney to the reddened surface, covered with foam dressing. 06/04/19: Stage 4 wound to sacrum. Low air mattress applied on May 28, 2019. 5.5 cm L x 4.3 cm w no tunneling. Care plan dated 08/01/17 reviewed. -Focus: "R60 is high risk for skin breakdown or other pressure ulcer development R/t incontinence, decreased mobility and poor nutrition/ wt. loss. Goal: will decrease risk for pressure ulcer development through next review. Interventions: Avoid shearing resident's skin during positioning, turning, and transferring. Observe skin every shift with special attention to bony prominence and report changes. Turn and reposition at least every 2 hours. Use Air loss mattress in bed. Rojo cushion on w/C at all times Initiated: -Focus: The resident has infection of Sacral wound. date initiated: 07/04/19.	4 136		

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4 136	Continued From page 8 Weekly wound assessment dated 10/29/19 reviewed. Stage 4 pressure ulcer, Length 3 cm x width 4.5 cm x depth 1 cm. with 2.5 cm tunneling and 1 cm tunneling. Progress notes by Advanced Practice Registered Nurse (APRN) dated 01/07/20 reviewed. Chronic pressure ulcer of sacrum with delayed healing, due to overall frailty. Has pressure relieving mattress and staff very aware of need for strict 2 hourly position changes. Weekly wound assessment dated 01/28/20 reviewed. Stage 4 pressure ulcer. Length 5.0 cm (increased from 3.0 cm on 01/17/20). Width: 4.0 cm (increased from 3.5 cm on 01/17/20) x depth. 0.7 cm. Progress notes reviewed. In March 2019 developed a pressure injury. Superficial pressure sore. By May 17, APRN came to see resident, changed orders and evaluated the wound. Stage 4 pressure injury. Had an infection and fever on May 26, 2019. Treated with antibiotics and ordered a pressure relieving mattress. Nurses notes dated 04/09/19 reviewed. Dietician recommended high protein supplement boost plus vanilla with meals three times per day (TID). Discontinued (D/C'd) the majic cup. Nurses notes dated 03/11/19 reviewed. Sacral open wound, stage 2. Clean with NS pat dry, apply bacitracin ointment and cover with foam, cleanse once daily and as needed (PRN). During an interview with her two Family member (F)1 and F2 on 02/03/20 at 11:54 PM stated that R60 does not mind being turned but I know the staff aren't turning her. I also think they don't give	4 136		

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4 136	Continued From page 9	4 136		

her enough water. F2 added, I know they're not turning every two hours, because I come in early in the morning and sometimes I'm here late at night and I ask the staff why they're not turning her every 2 hours and they make excuses like saying she just ate.

05/17/19: Physician (MD) note dated 05/17/19 reviewed. Wound Care- cleanse with NS Santyl to slough every day (QD) and PRN if excessive drainage or soiled d/t BM.
Medi Honey to granulation tissue QD and prn if excessive drainage or soiled d/t BM. Boarded foam dressing. Dx, sacral pressure ulcer.

APRN order dated 11/12/19 reviewed. "Vitamin C 500 mg po BID, Zinc 220 mg PO daily"

During an interview with the Registered Dietician (RD) on 02/03/20 at 12:36 PM stated R60 has a history of adult failure to thrive and sepsis. Always a challenge to eat and maintain her weight, she had a gradual decline. She was on hospice in 2016 and off in March in 2017 back on august 2017 then discharged from hospice on 2017. She weighed 82 pounds in August of 2017 and in December was 80 pounds, January 2018 went up to 86 pounds. Last weight for her was 78.4 lbs, she is stable now.
She is offered majic cup at meals, and boost plus at meals. Overall she drinks the boost plus and it should be helping with the wound healing. She get's extra vitamins and minerals and she gets a lot of juices on her tray. I see her every three months, or if there was a sudden drop of her weight.

During an interview with LN 52 on 02/03/20 at 01:00 PM, was asked how often is R60 turned stated every two hours. The certified nurse aides

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(CNA's) change the brief at 7 am just before shift change, at 8 am they make first round, at 10 AM they turn again, at 12 they place her in straight position. At 2 PM they turn again. When I change her dressing at 10:00 AM she was on her side.

During an interview with an anonymous staff on 02/03/20 at 01:37 PM when asked why R60 has not been turned onto her side every 2 hours and confirmed with surveyor observations over the past few days, quietly stated that with the staff we have here during any shift, we really can only turn her every 2-3 hours, we need more staff to be able to turn her every 2 hours.

3) On 01/29/20 at 10:46 AM, R111 states that he does not utilize his CPAP mask at night because it is uncomfortable. He prefers to receive oxygen through the nasal cannula (tubing to deliver oxygen into his nose) at 2 liters per minute continuously.

Observed R111 using oxygen tubing that was not dated, into his nares. This was connected to a dusty oxygen concentrator with a dirty filter, set at 2 liters per minute.

"Order Listing Report" with date range 01/01/2020 to 01/31/2020 reviewed. There was an "Active" order for "BiPAP [bilevel positive airway pressure] @ 22/16 [pressure] with 2 L [liters of oxygen] bleed-in every evening and night shift for OSA [obstructive sleep apnea] *ON: when sleeping."

R111's medical record was reviewed. There was no physician's prescription for the oxygen utilized in place of the CPAP machine. There was no nursing or respiratory therapist documentation indicating that the physician was notified for

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4 136	Continued From page 11 R111's refusal to wear his CPAP machine. Review of R111's current care plan revealed a "Focus" for " ...oxygen therapy r/t [related to] Ineffective gas exchange" initiated on 01/08/2020. "Interventions" listed "OXYGEN SETTINGS: O2 via nasal prongs @ 1 L continuously" initiated on 01/08/2020. During an interview with the nurse manager (NM) 1 on 01/31/20 at 10:23 AM, the SA informed NM1 that R111 received oxygen at 2 liters/minute with no physician's prescription. NM 1 was also informed of R111 refusal to use his CPAP at night and of his preference to utilize oxygen at 2 liters/minute. SA also indicated that there was no documentation in the medical records that the physician was notified of this.	4 136		
4 138	11-94.1-36(b) Admission, transfer, and discharge (b) These policies shall ensure that: (1) The facility shall not discriminate against admission of any individual as per all federal and state civil rights and anti-discrimination regulations. Should the facility not be able to provide care and services to individuals based on their age, i.e., infants and youth, or specific disability, the facility will need to indicate so in their policies and procedures and by-laws; (2) The facility shall accept only those residents whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts; (3) As changes occur in a resident's physical	4 138		4/2/20

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4 138	Continued From page 12 or mental condition necessitating a different level of service or care that cannot be adequately provided by the facility, the residents shall be transferred promptly to a facility capable of providing an appropriate level of care; (4) Except in the case of an emergency, the resident or the resident's legal guardian, family, or surrogate and the attending physician shall be informed in advance of the transfer or discharge to another facility; and (5) The facility's buildings are constructed, equipped, and maintained to protect the resident's health, and assure the safety of residents, personnel, and visitors. This Statute is not met as evidenced by: Based on interviews, record review, and review of the facility's "Transfer Form" policy, the facility failed to furnish the appropriate resident information to the receiving provider to ensure the resident's safe and orderly transfer and continuity of care. Findings include: 1. During an interview with R111 on 01/29/20 at 10:40 AM, the resident stated that he went to an acute care clinic because his foot was bleeding. He is unable to recall the reason as to why his foot was bleeding. A record review was done. On 12/25/19, the day of R111's transfer, registered nurse (RN) progress notes state, "Oriented to person, place and time." The "Physician's Discharge Summary," dated	4 138	An audit was performed on the current policy and procedure surrounding the transfer of residents from this facility. This review identified conflicting information on several different policy statements. An audit was performed on the current transfer forms used to provide information to the receiving facilities. As a result of this audit both the transfer policy and procedure and the form surrounding resident transfer were revised and rewritten. The SDC provided education to the nursing leadership on March 24, 2020 regarding the change in policy & procedure and instruction on the revised transfer form so that the nursing staff at their individual units would know of the current changes. Nursing staff were	

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4 138	Continued From page 13 01/24/20 was handwritten and difficult to decipher to relay necessary information to the receiving provider in order to meet the resident's needs. "Transfer Form" policy reviewed. The transfer form will be completed by the nurse and will include: " ...o. All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care." Also, "3. A copy of the Transfer Form will be filed in the resident's medical record." On 02/03/20 at 07:45 AM, State Agency (SA) inquired with Licensed Nurse (LN) 17 if the "Transfer Form" sent to the receiving facility is kept in the resident's chart. LN17 states that she will inquire with the unit manager regarding this. On 02/03/20 at 09:30 AM, SA made a records request for R111's transfer documents with Staff (S) 22. During an interview with LN95 on 02/03/20 at 10:43 AM, LN95 stated that the "Transfer Form" is done on a "case by case basis" depending on the "acuity of the resident." The records request for R111's transfer form and accompanying documents was made again with LN95. No records were received by 01:30 PM on 02/03/20. LN95 stated that the documents that were sent to R111's receiving provider on his 12/25/19 transfer, were his "MAR [medication administration record], labs, face sheet and order summary."	4 138	educated on changes in procedures on March 18 and 19, 2020 in informal huddles and staff meetings held by D.O.N. Further education will be provided on 4/2/2020 to the resident care staff regarding the changes in the policy and procedure for transfer, and the required documentation of all transferred residents out of the facility. The SDC also provided education to medical records personnel on 3/25/2020 and gave instruction to have unit clerks made aware of the new policy and form. On the same date medical records staff conducted an inventory of current transfer forms in supply and have placed the revised transfer form in circulation. At the facility's monthly QAPI meeting the social services director will report on the number of resident transferred from the facility and their disposition.	
4 148	11-94.1-39(a) Nursing services	4 148		4/6/20

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4 148	Continued From page 14 (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observations, record review, and interviews with the following residents (R) 148, and R60, the facility failed to have sufficient staff available to provide nursing care and services to assure resident safety and attain or maintain their highest practicable physical, mental, and psychosocial well-being. The deficient practice potentially increases the likelihood of poor health outcomes, such as incontinence, and one resident, R60 developing a chronic stage 4 pressure ulcer that was acquired in the facility. Findings Include: Cross reference to F838 1) During an interview with R148 on 09/29/20 at 10:30 AM, R148 relayed that he/she had to wait between thirty minutes to one hour for staff to respond to the call bell. R148 said that several times, he/she would be "lying in a wet diaper" or "lying in stool" waiting for staff to respond. R148 further stated that this concern had been reported to facility management in the past with little change or improvement. A review of records for R148 showed an admit date 02/01/18 with diagnosis including Amyotrophic Lateral Sclerosis (ALS), Tracheostomy, Gastrostomy, Dysphagia,	4 148	On 3/9/2020 the facility administrator was interviewed by a national healthcare consultant to review and discuss the status of the Facility Assessment. On 3/10/2020 the facility administrator and consultant reviewed the resident population, resources available to the facility, and the facility risk assessment. It was identified at that consultation there were data unavailable to provide a complete facility assessment to identifying care standards and resources available to support the range of care provided. On 3/17/2020 the facility assessment was completed including an evaluation of the CMI score for the previous 5 months used as a gauge from which staffing resources would be applied. Within the facility assessment is now included: -An outline for staff competencies to be completed -An identification of nursing hours per patient day to support the care -Material resources necessary to provide the higher standards of care The facility is actively involved in advertising, recruiting and hiring staff into vacant positions to support the hours per	

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4 148	Continued From page 15 Dysphonia, Lack of Coordination, Polyneuropathy. According to the quarterly Resident Assessment Instrument - Minimum Data Set with the Assessment Refence Date 01/16/20, R148 was totally dependent on care. 2) R60 is an 80 year old female with Diagnosis of stage four pressure ulcer of the sacrum. During several observation's of R60 on 01/30/20 at the following times: 11:45 AM; 12:30 PM; 01:15 PM; 02:00 PM; noted the resident was laying in bed in semi fowlers position on her back without being repositioned. During an observation on 01/31/20 at 09:10 AM noted R60 slightly elevated in bed being assisted with her breakfast meal by the RNA. During observations at 10:30 AM; 11:00 AM; and 12:15 PM noted R60 sitting in same position with eyes closed. During several observations of R60 on 02/03/20 at the following times: 08:10 AM; 09;17 AM; 10:00 AM noted R60 lying in bed on her back in the same position. During an interview with Licensed Nurse (LN)52 on 01/30/20 at 02:06 PM confirmed that R60 has a stage 4 pressure ulcer to the sacrum acquired in the facility on 03/3/19. Following Skin observation tool's reviewed: 03/13/19; open skin to sacral area stage 2 with treatment (tx) of bacitracin covered with foam dressing after cleansing with normal saline (NS). 04/23/19; open skin to sacral area with tx of bacitracin covered with foam dressing daily & PRN.	4 148	patient day standard. A review of the orientation process and competency education has been completed. The new orientation process for staff hired will begin 3/23/2020. Off shift nursing supervisory staff and the unit managers have received direction from the DON to provide staffing to support the hours per patient day standard. To address residents' skin and weight concerns the facility has organized monthly skin and weight meetings. These meetings will include the dietary manager, unit managers, dieticians, ADON, & DON. The meeting will address the following: -New admissions -Residents with wounds -Weight loss -Weight gain Pressure Ulcer management education was provided to the nursing care staff during the meetings on 3/18 - 3/19/2020 focusing on the importance of resident position and turning. The facility has adapted the use of a turning clock to be used to identify a timeframe for which the staff will be turning the residents. The turning clock tool was inserted into daily nursing practice on 4/1/2020. Follow up education will be provided through informal staff huddles on 4/2 and 4/3/2020. The SDC will provide education for wound assessment and classification through the upcoming skills fair (4/13 - 4/17/2020) and	

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4 148	Continued From page 16 05/29/19; stage 4 sacral injury appears moist 80 percent (%) slough yellowish-brownish adherent tissue, surrounding skin slightly reddened and partially macerated wound edges. 06/04/19; treatment plan changed to the following: cleansed with dakins solution applied Santyl to slough area and medihoney to the reddened surface, covered with foam dressing. 06/04/19: Stage 4 wound to sacrum. Low air mattress applied on May 28, 2019. 5.5 cm L x 4.3 cm w no tunneling. Care plan dated 08/01/17 reviewed. -Focus: "R60 is high risk for skin breakdown or other pressure ulcer development R/t incontinence, decreased mobility and poor nutrition/ wt. loss. Goal: will decrease risk for pressure ulcer development through next review. Interventions: Avoid shearing resident's skin during positioning, turning, and transferring. Observe skin every shift with special attention to bony prominence and report changes. Turn and reposition at least every 2 hours. Progress notes by Advanced Practice Registered Nurse (APRN) dated 01/07/20 reviewed. Chronic pressure ulcer of sacrum with delayed healing...staff very aware of need for strict 2 hourly position changes. Nurses notes dated 04/09/19 reviewed. Dietician recommended high protein supplement boost plus vanilla with meals three times per day (TID). Discontinued (D/C'd) the majic cup. Nurses notes dated 03/11/19 reviewed. Sacral open wound, stage 2. Clean with NS pat dry, apply bacitracin ointment and cover with foam, cleanse once daily and as needed (PRN).	4 148	ongoing staff in-services. The Aloha Wound Care team does a weekly in house visit to assess, debride and give treatment recommendations. Through the past several months the nursing leadership has been working with the EMR resources to facilitate the implementation of a Skin & Wound software. This program will help tracking and review of current and new wounds. It will aid nursing staff with the assessment and appropriate documentation of these wounds. The wound care coordinator is a component part of the Aloha Wound Care team and is a staff member of the facility. Wound care coordinator will be responsible for auditing the condition of the resident's wounds and providing care direction and feedback to the nursing staff. At the monthly QAPI meeting the wound care coordinator will give a report of the progress of the wounds managed by the Aloha Wound Care Team. The maintenance staff did a survey of the facility to assess the presence of call bells for all residents. From this survey it was identified that each occupied bed is complete with the necessary call bell cable for the resident to summon help as necessary. The nursing staff will be informed of the importance of having the call bell system within reach for all those residents who are cognitively aware of their own needs. -Additionally they will adapt the use of the 4 P's upon leaving the resident's bedside:	

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4 148	Continued From page 17 During an interview with her two Family member (F)1 and F2 on 02/03/20 at 11:54 PM stated that R60 does not mind being turned but I know the staff aren't turning her. I also don't think they give her enough water. F2 added, I know they're not turning her every two hours, because I come in early in the morning and sometimes I'm here late at night and I ask the staff why they're not turning her every 2 hours and they say "she just ate" or giving some other excuse. There is difficulty in endorsement to the staff in meeting our mom's needs, we ask the staff to help by making sure she has her sweater on because she gets cold, or putting her sleeves on because she has fragile skin and gets a lot of skin tears and bruises. Many times when I come in she's cold, and she has no sweater on. She needs to wear a sweater or a jacket. I've asked the staff several times but it doesn't seem to be working. It seems like the staff need more training in caring for frail elderly. During an interview with LN 52 on 02/03/20 at 01:00 PM, was asked how often is R60 turned stated every two hours. The certified nurse aides (CNA's) change the brief at 7 am just before shift change, at 8 am they make first round, at 10 AM they turn again, at 12 they place her in straight position. At 2 PM they turn again. When I change her dressing at 10:00 AM she was on her side. During an interview with an anonymous staff on 02/03/20 at 01:37 PM when asked why R60 has not been turned onto her side every 2 hours and confirmed with surveyor observations over the past few days, quietly stated that with the staff we have here during any shift, we really can only turn her every 2-3 hours, we need more staff to be able to turn her every 2 hours.	4 148	-Potty (toileting) -Positioning -Pain -Personal items (call light) Residents level of cognitive awareness will be assessed by using the BIMS scoring system. With the use of the facility's Daily Quality Assurance Rounds checklist management staff will be required to check for the following: -Cleanliness and overall appearance of room (including curtains) -Call light functionality -Call light within reach -Call light answered timely On 4/6/2020 the Daily Quality Assurance Rounds checklist will be a component part of the QAPI standup morning meeting where the checklist will be reviewed.	

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4 148	Continued From page 18 3) An abbreviated Resident Council (RC) meeting was held during the survey 0n 01/30/20 at 02:27 PM. There were fourteen in attendance to RC meeting. They were resident (R) 22, 148, 14, 93, 75, 41, 9, 155, 59, 72, 98, 143, 130 and 48. The concern regarding the call lights were brought up as a problem. We can wait up to 2 hours for the call light to be answered. This mostly happens during the evenings and when they go to break. R148 stated we have repeated these questions to the management level and there is no improvement. Another resident stated, I talk with the supervisor and nothing happens. Another resident stated, "when I go to the bathroom, I page someone on the call button, and I ask them nicely, but they want me to wait. Another resident chimed in about her roommate and says, "It's priority calls and they just leave her and attend to something else and sometimes she is waiting a long time." The nurses are short, and it is a priority thing. The clinical nurse assistants (CNA)'s in the am have to bathe people, change people and the nurse comes in and gives us the pills and leave. R14 joins in and voices that "On our unit, the respiratory therapists have been told that they have to answer call lights. R72 chimes in and says "A lot of times, walking through the hall, staff ignore the lights since we are residents here. Things are talked about but nothing changes. If you want to come back to talk about the call light, they shut you down. We should be able to voice our concerns without being shut down. R48 states "In the back, there is 24 patients and sometimes there is only two CNAs and then there is five lights on, and the CNA don't come for one hour. Nobody come and	4 148		

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4 148	Continued From page 19 I watched another resident wait two hours for someone to take him/her to their room. They are lacking CNAs. My aunty is on unit 4 and I go up at 2:00 PM to check that her snack has been given to her. A lot of times, the snack is still in the hallway. I was concerned about her because she is only 69 lbs. Residents stated "We can talk but we are concerned about the ones that cannot talk and the way people are treated that cannot talk. Residents stated that at dinner, there is only one staff and she cannot handle all the residents in the dining. They drop off the patients and leave them with the one person. The one person cannot help all the residents by herself/himself. Record Review (RR) on 01/30/20 at 01:17 PM of resident council minutes dated November 29, 2020 - talks about - a resident waiting about 2 hours to be assisted back to bed in the evening shift. Action taken by the facility was the assistant Director of Nursing (ADON) explained to the members that evening shift has less staff and that staff may have gone to break during that time. Respiratory therapy, (RT) manager was already aware of the concern and that he will remind respiratory therapists that they are all responsible to answer call lights. Interview with the DON on 01/30/20 at 07:15 AM. DON confirmed that everybody can answer the call lights. On 02/03/20 01:19 PM, inquired with staff development coordinator (SDC) regarding staff training and competencies conducted by the facility. SDC confirmed the facility does not have a system in place that is able to identify between	4 148		

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4 148	Continued From page 20 staff that has completed training versus staff that have not completed training. SDC stated that staff is currently undergoing training. This surveyor requested to review a sample of the completed Annual Mandatory In-Service training. Reviewed staff (S)1's Annual Mandatory In-Service training. On 07/31/19, S1 had completed written training, however, the completed training was not corrected or verified by the SDC. The SDC confirmed the facility is unable to verify the answers provided by S1 on the Annual Mandatory In-Service was correct. Furthermore, the facility was unable to provide documentation ensuring all nursing staff have meet the specific competency requirements as part of their license and certification requirements defined under State law or regulations. A review of the Facility Assessment provided to the surveying team during the entrance conference was dated October 2018. The facility assessment for staff competencies and overall acuity of the units was blank and did not contain any information. On 02/03/20 at 11:17 AM, inquired with the Administrator and the Director of Nursing (DON) regarding the staff training and the ability of the facility to ensure staff have the appropriate competencies and skills necessary to care for the residents of the facility. The DON confirmed the facility does not have a system that can denitrify staff that has completed training versus staff that have not completed training. Furthermore, both the Administrator and the DON confirmed the facility does not use a Facility Assessment when staffing the facility.	4 148		

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4 149	Continued From page 21	4 149		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on interviews, observation and record reviews, the facility failed to maintain an updated plan of care for three residents (R)2, and R3, and R111 of 41 sampled residents. The deficient practice fails to implement a current plan of care that is resident centered and meets the needs of the resident. Findings include: 1) Surveyor Interviewed R3's family member who	4 149	Nursing leadership staff will perform a room to room audit of resident care plans who occupy that room. On any given day the residents occupying each room will have their care plans reviewed and updated as indicated until all resident care plans for that unit are reviewed. Each care plan will be reviewed for: -Condition changes, new events, current medications, wounds, falls, behaviors,	3/23/20

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4 149	Continued From page 22 stated on 01/29/20 at 11:24 AM, whenever my family visits, my sisters, my daughter, my son, and me, we check his diaper and there is usually doodoo. He tends to dig, and we clean him up. We can smell it when we come in. Even if they clean it, the doodoo is in the trash can and the room smells. We must ask the janitor to clean. When you enter the room, we can smell the doodoo because they leave the doodoo diaper in the trash and then say they must call the janitor and it smells for a longer period. Surveyor interviewed the clinical nursing assistant (CNA) 157 on 02/03/20 at 11:43 AM, who stated, we have tried mittens and R3 knows how to take off the mittens. We try to check him every 30 minutes. We put the shorts backwards. We are going try long pants. We are not able to stay with him one on one. As soon as his hands are free, he likes to scratch by his doodoo, and we try hard to prevent this. The last time it happened was last week. We told the family that we check, less than 30 minutes at a time and we can't stay with him one on one. Surveyor reviewed R3 Care plan dated 06/15/19 that did not address the digging behavior in his personal hygiene goal and intervention. 2) During an interview will R111 on 01/29/20 at 10:23 AM, he stated that he does not receive insulin and that the staff do not check his blood sugars. R111's care plan reviewed. "Focus" initiated on 01/08/2020 " ...has potential having hyperglycemia [high blood sugar]. Accucheck [blood glucose monitoring] BID [twice a day] and humulin insulin SQ [subcutaneously] as ordered."	4 149	infections/isolation precautions -Specific resident centered care =Nursing: MEDs, ADLs, mobility =ADON/infection nurse: antibiotic, isolation precautions =Wound RNs: residents on wound round list =Activities: activities =Dietary: diet -Completed goals will be resolved -Active problems will be revised and addressed as indicated	

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4 149	Continued From page 23 The "Order Listing Report" with date range 01/01/2020 to 01/31/2020 was reviewed. It was noted that a "Completed" status existed for the order "Accucheck two times a day for HYPERGLYCEMIA for 7 days *Notify MD if BS less than 70 or greater than 350mg/dl". The medication administration record (MAR) for 01/01/2020 to 01/31/2020, revealed the last day of R111's Accucheck was on 01/10/20. R111's MAR also showed "HumuLIN R Solution 100 UNIT/ML (Insulin Regular Human) Inject 4 unit subcutaneously as needed for HYPERGLYCEMIA *Give before breakfast & before dinner (BID) if BS [blood sugar] is greater than 250mg/dl [milligrams per deciliter]." The 02/01/2020 to 02/29/2020 R111's MAR shows "HumuLIN R Solution 100 unit/ml (Insulin Regular Human) Inject 4 unit subcutaneously as needed for HYPERGLYCEMIA *Give before breakfast & before dinner (BID) if BS is greater than 250mg/dl." An interview with Licensed Nurse (LN)26 on 02/03/20 @ 09:15 AM, confirmed that R111 is not currently receiving blood glucose monitoring and insulin. Cross reference with tag 684 3) On 02/03/20 at 12:01 PM, a reviewed R2's care plan. The activity of daily living (ADL) portion of the care plan documented created on 02/26/15, listed an intervention which states R2 is able to feed self after set up. However, according to a review of R2's review of R2's Minimum Data Set (MDS) documenting a significant change in condition (readmission to the facility following a hospitalization) with an Assessment Reference	4 149		

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4 149	Continued From page 24 Date of 11/2/19, documented R2 requires extensive assistance for eating, with one staff assistance. Furthermore, R2 weighed 94 lbs, had loss 5% or more in the last month or loss 10% or more in the last 6 months, and was not a physician prescribed weight loss plan. A review of the electronic medical record (EMR), on 09/09/2019, the R2 weighed 107 lbs and on 01/03/2020, the resident weighed 95.2 pounds which is a -11.03 % Loss. On 02/03/20 at 10:19 AM, reviewed R2's care plan with Nurse Manager (NM)4. NM4 confirmed that R2's care plan was not revised following a significant change in condition to address and implement interventions that were specific and necessary in R2's care.	4 149		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure food was properly stored, served, and dishes were properly sanitized in	4 159	The dietary manager completed a review of the storage area for dry food. As a result of this review it was discovered	3/19/20

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4 159	Continued From page 25 accordance with professional standards for food safety. As a result of this deficiency, residents of the facility were all at risk of potential of of food contamination. Findings include: 1) On 02/29/20 at 08:25 AM, upon initial tour of the kitchen with the Dietary Manager (DM), observed an open box of uncooked Dececco Spaghetti Noodles in the dry storage room. The opened box was not stored in a closed container. DM confirmed according to the facility's policy and procedure, the box spaghetti noodles should have been stored in a sealed plastic bin after opening. 2) On 01/29/20 at 08:33 AM, the Dishwasher Temperature Log for December 2019 and January 2020 staff documented the temperatures of the wash cycle (150-165) Rinse (180-195) for breakfast, lunch, and dinner. The Dishwasher Temperature Log consistently logged the wash cycle as 100 degrees. Inquired with DM, about the documented temperatures of the dishwasher. DM stated, "They (staff) did not tell me about this." Inquired if temperature logs are monitored by DM, DM stated "Only when something is reported to me other than that I don't monitor it." DM confirmed dishes are sanitized by high temperatures (wash - 150-165 degrees F; final Rinse - 180 degrees F). Inquired with Kitchen Staff (KS)10, who operates the dishwashing machine. KS10 confirmed the temperatures during the wash cycle is consistently at 100 degrees Fahrenheit (F). Requested the DM to test the dishwasher temperature with Dishwasher Sensor Label (Lot	4 159	the need for a change in the practice of the storage of dry food. The dietary manager purchased a selection of containers appropriate for the storage of dry food. The staff received in-service on proper labeling and storage of dry food. This was completed on 1/29/2020, 1/30/2020, 2/3/2020. The dietary manager will be completing daily kitchen rounds two times each day. A log will be kept identifying appropriate food labeling, with open and discard dates. The dietary manager provided education to the kitchen staff related to dish sanitization on 1/29/2020, 1/30/2020 and again from 3/18/2020 - 3/19/2020. The education given outlined proper testing and documentation of dishwasher temperature, functionality of sanitizer, notification of defective equipment performance. The dietary manager contacted the equipment maintenance company. An evaluation of the dishwasher function was completed by the company. As a result of this evaluation, a new temperature gauge was installed. After the gauge was installed the function of the dishwasher was evaluated, and the water temperature was found to be within guidelines. An additional level of safety was installed. The equipment maintenance company installed a second stage sanitizing agent which is applied to dishes at the end of the wash cycle.	

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4 159	Continued From page 26 #050918105 expiration date 03/19/20). DM conducted 3 separate test using temperature test strips within a 20 minute time period. According to the temperature test strip instructions, the test strip will turn black in color when the temperature of the water reaches 160 F. DM confirmed all three strips did not turn black, even though the final rinse gauge on the dishwasher indicated the temperature was 204 F. Furthermore, when the dishes came out of the dish washer, the dishes were warm to touch. 3) On 02/29/20 at 09:15 AM, inspection of the manual washing and sanitizing (3-step process is used to manually wash, rinse, and sanitize dishware correctly) with DM. The third step is sanitizing with either hot water or a chemical solution maintained at the correct concentration. Inspection of a 3 compartment sink for , the last compartment (sanitizing compartment) was tested with the DM. The DM grabbed a test strip roll from a window sill ledge near the sink. The test strip was not stored in the appropriate container. Upon testing the sanitizing solution the test strip color did not turn green indicating that the solution was <150 ppm. Retested the solution with a new roll, same result. KS10 confirmed the concentration of the sanitation solution in the 3rd compartment was below the manufacturer's concentration recommendation of 150 ppm. 4) On 01/30/20 in preparation for lunch, observed serving utensils stored in 4 brown open bins. The open bins were stored directly under the steam serving line. The open bins contained various unknown liquids and unidentifiable brown particles in the open bins and on the serving spoons. Inquired with kitchen staff (KS)15, who had cooked and was about to plate the lunch	4 159	The kitchen staff was reeducated on the procedure for testing the sanitizing agent in the last compartment of the 3 compartment sink sanitizer. The equipment maintenance company provided validation of the testing strips used in the 3 compartment sink sanitizer. At each meal the sanitizing agent of the 3 compartment sink is tested for accuracy. Reeducating of the importance of cleanliness along the food prep line was provided to the kitchen staff, including all the resources necessary to ensure sanitary conditions at all times. This education was given on 3/18/2020.	

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4 159	Continued From page 27 trays with food. KS15 confirmed the utensils in the brown bins were used to serve food onto the resident's trays. KS15 confirmed the liquid and the brown particles in the open bins was food and liquids that fell off the serving area above the bins and there were no covers for the bins to protect the serving utensils from splashes and contaminates. 5) Observed 3 sectioned plate on the serving line that contained dried food particles which were stuck to the corner of the plate. KS15 confirmed staff it was dried food on the plate.	4 159		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to properly label a multi dose vial of vaccine with an opened date. The deficient practice has the potential to increase the risk of injury/ illness for residents residing in the facility. Findings include: During a medication storage inspection on 01/31/20 at 10:26 AM in the Unit 3 medication storage refrigerator, two influenza multi-dose vials were found in refrigerator. One vial had writing on the box that stated opened 01/08/20, although the bottle in the box is not labeled. The other box was labled opend 01/10/20, and the bottle in the box was not labeled. During an interview with the	4 197	The facility did a review of how medications are stored and labeled in each med cart in all four units. As a result of this audit the nursing leadership team have developed changes in the current medication management practices. The practice changes are as follows: -At the end of each shift, the licensed nurses sign off that all meds requiring open dates documented are labeled appropriately -Nursing clean up day: on last day of every month the Licensed Nurse will check each med cart, med/treatment room for expired medication, discharged medications,	3/23/20

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4 197	Continued From page 28 Unit Manager, validated that the bottle should have been labeled as well as the box since the vaccine could get placed back into the wrong box and potentially given to a resident after it expired.	4 197	ensure all meds requiring open date documentation are labeled appropriately.	